TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LONE STAR NEUROLOGY

Respondent Name
NEW YORK MARINE CO

MFDR Tracking Number
M4-18-0209-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
SEPTEMBER 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position Summary was not submitted in the request for medical fee dispute packet.

Amount in Dispute: $7,496.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We escalated this review to our bill review vendor and based on additional review have issued payment to Lone Star Neurology in the amount of $2129.31 additional owed based on fee guidelines."

Response Submitted by: CCMSI

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2016 through December 10, 2016	CPT Code 95951-59-76 (X3)	$7,496.76	$0.00
	CPT Code 95957-59-76 (X3)	$0.00	$0.00
	CPT Code 93268-59-76 (X3)	$0.00	$0.00
TOTAL		$7,496.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.1, effective March 1, 2008, provides for fair and reasonable

reimbursement of health care in the absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers Compensation jurisdictional fee schedule adjustment.
   - 86-Service performed was distinct or independent from other services performed on the date of service.
   - 259-Repeat procedure performed by the same physician.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1014-The attached billing has been re-evaluated at the request of the provider based on the re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 1240-Payment disallowed-Reimbursement decision previously rendered.
   - 5056-Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s).

Issues

1. What is the applicable fee guideline for professional services?
2. Is the requestor entitled to additional reimbursement for code 95951?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. Based upon the submitted documentation the requestor billed $9,000.00 for code 95951-59-76. The respondent initially paid $1,503.24 leaving a balance of $7,496.76. The respondent states "We escalated this review to our bill review vendor and based on additional review have issued payment to Lone Star Neurology in the amount of $2129.31 additional owed based on fee guidelines." Based upon this additional reimbursement, only $5,367.45 remains in dispute for code 95951-59-76.

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   On the disputed date of service the requestor billed the following:

   - CPT code 95951 is described as "Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours."
   - CPT code 95957 is described as "Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)."
   - CPT code 93268 is described as "External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional."
   - The requestor appended modifiers "59- Distinct procedural service" and "76-Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional" to these codes.

   Because code 95951 does not have a relative value assigned by Medicare, the code is subject to 28 Texas Administrative Code §134.203(f).

   Per 28 Texas Administrative Code §134.203(f), "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1, requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $5,367.45 for CPT code 95951-59-76 (X3) would be a fair and reasonable rate of reimbursement. As a result, payment cannot be recommended.

To determine if additional reimbursement is due for codes 95957 and 93268 the division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Place of Service is 11-Office Based.

The 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75035, which is located in Frisco, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

Using the above formula, the division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Carrier Paid	Amount Due
95957	$298.71	$474.04 X 3 units = $1,422.12	$1,422.12	$0.00
93268	$192.07	$304.81 X 3 units = $914.43	$914.43	$0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		12/13/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.